



The health status of asylum seekers screened by Auckland Public Health in 1999 and 2000

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Abstract

Aim Approximately 1500 to 1800 applications for refugee status are made to the New Zealand Immigration Service each year. Approximately one third of these asylum seekers receive health screening from Auckland Public Health. We report here key findings from this screening programme for the period 1999 to 2000.

Methods The files of patients attending the Auckland Public Health Protection Asylum Seekers Screening Clinic at Green Lane Hospital were reviewed. Data on demographics, medical examination, diagnostic testing and referrals were analysed.

Results Nine hundred people, mainly from Middle Eastern countries, received screening. Important findings were: symptoms of psychological illness (38.4%); Mantoux skin test positivity (36.4%); active tuberculosis (0.6%); TB infection requiring chemoprophylaxis (18%) or chest X-ray monitoring (15%); gut parasite infection; carrier state for alpha and beta thalassaemia and the heterozygous states for HbS and HbE; incomplete immunisation; and the need for referral to a secondary care service (32.6%).

Conclusions Immigrant communities in New Zealand have special healthcare needs, as well as experiencing language barriers, cultural differences and economic difficulties. Healthcare providers should be alert to these needs. Appropriate resources are required to address these issues in a timely fashion.

In addition to the 750 prearranged quota refugees that New Zealand accepts annually, approximately 1500 to 1800 applications for refugee status are made to the New Zealand Immigration Service each year by those spontaneously arriving in the country seeking asylum (personal communication, N. Wong, New Zealand Immigration Service, 4 March 2002). These asylum seekers have often fled situations that carry the same risk of physical injury, disease and psychological trauma as those of quota refugees. Whilst only 20–30% of these asylum-seekers will eventually gain residency as refugees, New Zealand has a moral obligation to provide them with adequate health care in the months to years it can take to process their claims. The majority of asylum seekers entering the country remain in the Auckland area.¹ In contrast to the quota refugees, who automatically receive comprehensive medical screening and care at the Mangere Refugee Resettlement Centre, asylum seekers live in the community and their health screening is voluntary.

Those who declare their intention to seek asylum at Auckland airport are invited to attend free health screening with the Auckland Public Health Service. They are considered high priority for screening because they are likely to have lived under prolonged conditions of hardship with limited access to health care. Others enter the

country on a visa for some other purpose and declare to a lawyer in New Zealand their intention to seek asylum. They hear of the screening service by word of mouth.

Screening is carried out by doctors and includes a medical history, physical and psychological examination, forensic examination, screening tests, and referrals to a general practitioner and possibly secondary services. The screening service is independent from the refugee-status application process and does not affect it.

We report here key findings from this screening programme for the period 1999–2000 in the hope that this will allow the complex health needs of this group to be better understood and met by New Zealand healthcare providers.

Methods

The files of patients attending the Auckland Public Health Protection Asylum Seekers Screening Clinic at Green Lane Hospital between 1 January 1999 and 31 December 2000 were reviewed. Data on the stated nationality, age, gender, degree of English spoken, reporting of psychological symptoms and referrals made, were transcribed onto data sheets. Results of Mantoux tests, chest X-rays, selected screening blood tests and faecal testing for parasites were recorded. A Mantoux result = 10 mm was considered positive.² The blood test results included full blood count analysis, haemoglobinopathy screening, ferritin levels, schistosomal serology, and presence of treponemal antibodies, hepatitis B surface antigens and antibodies, hepatitis C antibodies, rubella antibodies, and HIV antibodies. Parental recall of children's immunisation status was recorded (full, partial, nonexistent or unknown). Labplus or Diagnostic Medlab laboratory parameters, as printed with each result, were used to determine the normality of blood tests. Data were analysed using Epi Info 2000.³ Relative risks (RR) and 95% confidence intervals (CI) were calculated for exposures, with corresponding *p* values.

Results

Nine hundred people received health screening at the Auckland Public Health Protection Asylum-seeker Screening Clinic in 1999 and 2000.

Table 1. Demographic characteristics in screened asylum seekers, Auckland, 1999–2000

	Number	Percentage (%)
Nationality		
Iranian	168	18.7
Afghan	146	16.2
Sri Lankan	138	15.3
Czech	133	14.8
Kuwaiti	65	7.2
Somali	46	5.1
Iraqi	41	4.6
Other	163	18.1
Age (years)		
0–9	157	17.4
10–19	115	12.8
20–29	273	30.3
30–39	246	27.3
40–49	79	8.8
50–59	20	2.2
60+	6	0.7
Unknown	4	0.4

Six hundred and twelve subjects were male (68.1%) and 287 were female (31.9%). Gender was not recorded for one person.

The nationalities and age groups of attendees are recorded in Table 1.

Clinic doctors felt 243 (27.0%) asylum seekers had a command of English sufficient for a medical consultation without the aid of an interpreter, while 561 (62.3%) asylum seekers did not. For 96 (10.7%) asylum seekers this information was not recorded.

Symptoms, or history of symptoms, of psychological illness were reported by 345 subjects (38.4%). In comparison to all other nationalities, Iranians were more likely to report psychological symptoms (RR 1.5, 95% CI 1.2 to 1.7, $p=0.001$). Those under 20 years of age were less likely than adults to report such symptoms (RR 0.21, 95% CI 0.15 to 0.30, $p<0.001$). One hundred and seventy seven people (19.7%) were referred to some form of continued counselling or psychiatric care. Men were more likely to be referred than women (RR 1.7, 95% CI 1.2-2.3, $p=0.002$).

Rates of positive infectious disease serology in the screened population are shown in Table 2.

Table 2. Infectious disease serology results in screened asylum seekers, Auckland, 1999–2000

Serological test	Number (%) tested	Number (%) positive of those tested	Association with region of origin (RR)
Schistosomal Ab	874 (97.1)	28 (3.2)	African origin (RR 2.2, 95% CI 1.0, 5.0, $p=0.081$)
Anti HBs	851 (94.6)	140 (16.5)	
HBsAg	885 (98.3)	26 (2.9)	Somali origin (RR 6.7, 95% CI 3.0, 15.2, $p<0.001$)
Anti HCV	852 (94.7)	10 (1.1)	African origin (RR 13.1, 95% CI 3.4, 49.9, $p<0.001$)
HIV Ab	900 (100)	10 (1.1)	African origin (RR 13.1, 95% CI 3.4, 49.9, $p<0.001$) Sub-Saharan African (RR 28.5, 95% CI 8.3, 97.2, $p<0.001$)
Treponemal Ab	866 (96.2)	9 (1.0)	African origin (RR 44.8, 95% CI 5.7, 355.5, $p<0.001$)
Rubella Ab	850 (94.4)	739 (86.9)	

Ab = antibodies; Anti HBs = antibodies to hepatitis B surface antigen; Anti HCV = antibodies to hepatitis C virus; HIV Ab = Human Immunodeficiency Virus antibodies

Eight hundred and sixty nine people (96.9%) had a Mantoux skin test, of whom 316 (36.4%) had a result of 10 mm or more. Anti-tuberculous chemoprophylaxis was prescribed for 160 people (18.4% of those Mantoux tested). Seven hundred and eighteen people (79.8%) had a chest X-ray, of which 4 (0.6%) were reported to be suspicious for active tuberculosis, 26 (3.6%) showed signs of old tuberculous infection and 688 (95.8%) reportedly showed no evidence of tuberculosis. Serial chest X-ray monitoring was arranged for 132 people (18% of the cohort). Twelve people received full multi-drug treatment for tuberculous disease, including 4 with

active disease on chest X-ray and 8 whose chest X-ray suggested old tuberculosis but who were considered by a chest physician to warrant treatment.

Giardia lamblia infection was detected in 52 people (5.7%). *Ascaris lumbricoides* ova were found in the faecal specimens of 32 people (3.6%). Twenty people (2.2%) were found to be infected with hookworm, 13 of whom were Sri Lankan (RR 10.3, 95% CI 4.2 to 25.2, $p < 0.001$). *Hymenolepis nana* infection was found in 15 people (1.7%). *Blastocystis hominis* was found at pathological levels in the faeces of 7 people (0.8%). Afghans were found to be at an increased risk of carriage of gut parasites in comparison with other nationalities: RR 3.0 (95% CI 1.7 to 5.1, $p < 0.001$) for *Giardia lamblia*; RR 18.4 (95% CI 8.1 to 41.8, $p < 0.001$) for *Ascaris lumbricoides*; and RR 20.7 (95% CI 5.9 to 72.3, $p < 0.001$) for *Hymenolepis nana*.

None of the study subjects was affected by a haemoglobinopathy to the extent they had a clinical disease. However, the carrier state for alpha and beta thalassaemia and the heterozygous states for HbS and HbE were found as recorded in Table 3.

Table 3. Blood-related pathology in screened asylum seekers, Auckland, 1999–2000

Condition:	Number (%) tested	Number (%) positive of those tested	Association with region of origin, gender or other risk factor
α -thalassaemia trait	900 (100)	109 (12.1)	
β -thalassaemia trait	900 (100)	15 (1.7)	Afghan origin (RR 3.4, 95% CI 1.2, 9.5, $p = 0.03$)
HbS (heterozygous)	900 (100)	11 (1.2)	African origin (RR 25.2, 95% CI 5.5, 115.4, $p < 0.001$)
HbE (heterozygous)	900 (100)	5 (0.6)	Afghan origin (RR 7.7, 95% CI 1.3, 46.0, $p = 0.04$)
Anaemia	885 (98.3)	31 (3.5)	Female gender (RR 5.3, 95% CI 2.5, 11.4, $p < 0.001$) Somali origin (RR 3.6, 95% CI 1.4, 8.9, $p = 0.016$)
Low ferritin	879 (97.7)	202 (23.0)	Female gender (RR 2.5, 95% CI 2.0, 3.1, $p < 0.001$)
Eosinophilia	869 (96.6)	136 (15.7)	Afghan origin (RR 2.0, 95% CI 1.4, 2.8, $p < 0.001$) Sri Lankan origin (RR 1.7, 95% CI 1.2, 2.4, $p = 0.006$) Strongyloidiasis (RR 6.5, 95% CI 5.6, 7.6, $p = 0.001$) Hookworm infection (RR 4.5, 95% CI 3.1, 6.5, $p < 0.001$) Ascariasis (RR 2.5, 95% CI 1.5, 4.0, $p = 0.003$)

Parents reported for those 18 years and younger, that 94 (36.2%) had been previously “fully immunised” according to the immunisation schedule for their country of birth, 6 (2.3%) had received no immunisations, 64 (24.6%) had been “partially immunised”. For 96 (36.9%) immunisation status was unknown.

Five hundred and eighty nine patients (65.4%) were referred solely to a general practitioner, following health screening, for ongoing medical care. Eighteen people (2.0%) were not noted to have been referred to any further services. Two hundred and ninety three people (32.6%) were referred to services in addition to a general practitioner, as recorded in Table 4.

Table 4. Referrals to services other than a GP for screened asylum seekers, Auckland, 1999–2000

Service referred to	Number referred (%)
Refugees as Survivors (counselling service)	165 (18.3)
Respiratory Medicine (Green Lane Hospital)	32 (3.6)
Paediatric Tuberculosis Clinic (Starship Children's Hospital)	24 (2.7)
Plunket	21 (2.3)
Infectious Diseases (Auckland Hospital)	12 (1.3)
Community Mental Health Services	10 (1.1)
Other services	58*

* Less than 1% of the cohort was referred to each of the following: Red Cross Family Tracing Service (8 referrals), Ophthalmology (7), Orthopaedic Surgery (6), Sexual Health Clinic (6), Neurology (5), Inpatient Psychiatry (4), Otorhinolaryngology (4), Obstetrics (3), Orthotics (2), Paediatric Infectious Diseases (Starship Children's Hospital) (2), Paediatric Surgery (2), Urology (2), Auckland City Mission (1), Community Child, Adolescent, and Family Service (1), General Surgery (1), Neurosurgery (1), Paediatric Haematology/Oncology Clinic (1), Psychiatric Crisis Team (1), Speech Language Therapy (1).

Discussion

Review of the asylum-seeking population that attended the Auckland Public Health Protection Asylum Seekers Screening Clinic in 1999 and 2000 reveals important demographic characteristics of this group that may assist service planning.

More than two thirds of attendees were male and greater than 88% of attendees were under 40 years of age, reflecting perhaps the sectors of society more willing or able to journey to unknown circumstances in a foreign land. A similar gender distribution was found in applications received by the Refugee Status Branch of the Immigration Service in the 1998/1999 and 1999/2000 fiscal years, suggesting gender is not a specific barrier to accessing the clinic screening service.⁴

In the calendar years 1999 and 2000, 3349 people applied for refugee status (personal communication, N. Wong, New Zealand Immigration Service, 4 March 2002), but only 900 people (27%) attended the voluntary screening clinic. One reason asylum seekers may be reluctant to attend voluntary screening is due to fears that any findings could adversely affect their refugee status application.⁵ Others may not have been aware of the clinic's existence; only 627 people declared their intention to apply for refugee status on arrival at New Zealand airports in the years 1999 and 2000 (personal communication, N. Wong, New Immigration Service, 4 March 2002) and it is at this time that asylum seekers are given details of the clinic. It is difficult to assess the extent to which these selection biases may have affected the generalisability of our findings to all asylum seekers.

Awareness of the major nationalities represented amongst those seeking asylum in New Zealand is important so that services can be culturally appropriate and thus more likely to be effective. In the period of this study, almost half the asylum seekers screened were from countries in the Middle East. In contrast to the more sizable proportion amongst quota refugees, only 13.4% of screened asylum seekers were from African countries. Asylum seekers from Sri Lanka and Czechoslovakia each comprised about 15% of the total asylum seekers screened in the years 1999–2000.

The significant burden of infectious disease found in asylum seekers reflects high incidence in their countries of origin. The prevalence of tuberculosis (TB) in the screened group was equivalent to 1333/100 000 while the prevalence of active TB in New Zealand (assuming a duration of 12 months for each case) would be approximately equal to 12.4/100 000 in 1999, and 9.9/100 000 in 2000.⁶ For this reason screening is indicated, for the benefit of those seeking asylum and the protection of the communities in which they settle. Vigilance for TB amongst healthcare professionals is important, as TB-infected refugees and asylum seekers can develop active TB disease long after screening.^{7,8}

HIV infection is an important public health issue. Only 1.1% of screened asylum seekers tested positive for HIV. However asylum seekers and refugees contributed 21.1% of new HIV diagnoses in New Zealand in 1999, and 17.4% in 2000 (personal communication, N. Dickson, AIDS Epidemiology Group, 21 June 2002). Education regarding 'safer sex' practices for infected people and their communities is of public health importance.

The non-infectious conditions of alpha- and beta-thalassaemia traits, sickle cell trait and HbE heterozygosity were also found at high rates in the screened asylum seekers, in keeping with the relatively high prevalence of these genetic defects in many of the asylum seekers' countries of origin. For this reason screening is important, particularly for couples planning to conceive, as the homozygous form of many of these conditions causes significant morbidity. New Zealand healthcare providers will need to be increasingly mindful of these conditions in their clinical practice.

Psychological symptoms were reported by 38.4% of those screened, indicating this is a marked problem faced by the asylum-seeking community. Reeve reported in his dissertation on quota refugee screening that 14% of those screened described significant psychological symptoms.⁹ Psychological symptoms may be more prevalent in the asylum-seeking community than amongst quota refugees due to a greater sense of uncertainty about their future. Also, quota refugees often arrive with their families but asylum seekers often worry about family left behind. The course of events after refugees and immigrants enter their host country can have a more profound impact on their mental health during resettlement than events before migration.¹⁰ Nearly one fifth of all those screened were referred to counselling services, although it must be remembered that counselling is a Western-orientated concept and may not be accepted by some asylum seekers.¹¹ Those not referred for counselling were managed by Public Health in conjunction with Community Mental Health Services. Social support needs were managed in a variety of ways including Plunket Society input for families, advice on language courses, provision of material necessities (blankets, food vouchers, access to benefits), advice on tracing missing family members, and advice and reassurance about legal process.

Communication difficulties as a barrier to healthcare for refugees and the need for accessible interpretation services in primary care have been previously highlighted in New Zealand research.¹² The majority of asylum seekers in this group were felt by the screening doctor to require an interpreter in the consultation setting. This service, however, is not available free of charge to asylum seekers for any subsequent primary care consultations in the Auckland region, although it is in other parts of the country. Access to English language training is important because it can decrease the duration of asylum seekers' reliance on interpreter services.

Immigrant communities in New Zealand have special healthcare needs, as shown by the high prevalence of conditions discussed in this article, as well as experiencing language barriers, cultural differences and economic difficulties. Appropriate levels of funding are needed to address these issues in a timely fashion. Awareness by healthcare providers of the issues addressed in this article is also necessary, for the provision of better care to this group.

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